Wisconsin Medicaid
Home Health Agency Packet

Wisconsin
Department of
Health and Family Services

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Dear Medicaid Provider Applicant:

Thank you for applying for certification with the Wisconsin Medicaid program. Once you are a Medicaid provider, you will play a significant part in improving the health of low-income people in your community.

Enclosed are the certification materials you requested. Please review these materials carefully. These materials must be completed and processed before you may become a certified provider for the Wisconsin Medicaid program and begin receiving payments.

Upon certification as a Wisconsin Medicaid provider, you will receive the All Provider Handbook containing general instructions for all providers. In addition, you will also receive publications relating to the specific services you will be providing. These publications will identify the services covered by the Medicaid program and will describe Medicaid billing procedures. After reading those materials, if you have additional questions, we encourage you to use provider services. These services include both telephone and on-site assistance. If you are interested in using these services, please contact the Provider Services Unit addresses and telephone numbers listed in the All Provider Handbook.

We realize that all providers appreciate prompt payments, so we encourage providers with computers to submit claims electronically. This method reduces clerical errors and decreases turn around time. If you are interested in electronic submission of claims and would like more information, including the free software, please contact (608) 221-4746. Information is included in your certification materials regarding electronic submission of claims.

Thank you, again, for your interest in becoming a certified Wisconsin Medicaid provider and for the important services that you will provide to Medicaid recipients. If you have any questions about enclosed materials, please contact the Wisconsin Medicaid Correspondence Unit at (608) 221-9883 or toll-free at 1-800-947-9627.

Sincerely,

Peggy B. Handrich

Peggy B. Handrich
Associate Administrator

PBH:mhy
MA11065.KZ/PERM

Enclosure

Wisconsin Medicaid
Checklist for Certification

The items listed below are included in your certification application. Please use this form to check that you received the materials and verify which materials you returned. Please copy all documents for your records before sending them to the fiscal agent. Keep this checklist for your records. Mail your completed application to:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

The required items must be completed and returned to Wisconsin Medicaid:

	Item	Required	Optional	Date Sent
1.	Provider Application	X		
2.	Provider Agreement (2 copies)	X		
3.	Respiratory Care Services Affidavit		X	

These items are included for your information. Do not return them:

	Item
1.	General Information
2.	Certification Requirements
3.	Terms of Reimbursement
4.	Electronic Billing Information

Wisconsin Medicaid Program
General Certification Information

Enclosed is the certification application you requested to be a Wisconsin Medicaid provider. Your certification for Wisconsin Medicaid can be approved when you send a **correctly completed application** to the address below and meet all certification requirements for your provider type. **Wisconsin Medicaid cannot reimburse any services you provide prior to your approved certification effective date.** Please carefully read the attached materials.

Where to Reach Us

If you have questions about the certification process, please call the Wisconsin Medicaid Correspondence Unit for Policy/Billing Information at (608) 221-9883 or toll-free at 1-800-947-9627.

Copy all application documents for your records. Send your completed certification materials to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Certification Effective Date

Wisconsin Medicaid regulations are followed when assigning your initial effective date as described here:

1. The date you notify Wisconsin Medicaid of your intent to provide services is the earliest effective date possible and will be your initial effective date **if**:
   - You meet all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Medicaid on the date of notification. Do not hold your application for pending licensure, Medicare, or other required certification. Wisconsin Medicaid will keep your original application on file. Send Wisconsin Medicaid proof of eligibility documents immediately once available for continued processing.
   - Wisconsin Medicaid receives your **properly completed certification** application within 30 days of the date the application was mailed to you.

2. If Wisconsin Medicaid receives your application more than 30 days after it was mailed to you, your initial effective date will be the date Wisconsin Medicaid receives your correctly completed application.

3. If Wisconsin Medicaid receives your incomplete or unclear application within the 30-day deadline, you will be granted one 30-day extension. Wisconsin Medicaid must receive your response to Wisconsin Medicaid's request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension may allow you additional time to obtain proof of eligibility (such as license verifications, transcripts, other certification, etc.)

4. If you don't send complete information within the original 30-day deadline or 30-day extension, your initial effective date will be based on the date Wisconsin Medicaid receives your complete and accurate application materials.

Notification of Certification Decision

Within 60 days after Wisconsin Medicaid receives your completed application, you will be notified of the status of your certification. If Wisconsin Medicaid needs to verify your licensure or credentials, it may take longer. You will be notified as soon as Wisconsin Medicaid completes the verification process.

If you are certified to provide Medicaid services, you will receive written notice of your approval, including your Wisconsin Medicaid provider number and certification effective date.

Notification of Changes

Your certification in Wisconsin Medicaid is maintained only if your certification information on file at Wisconsin Medicaid is current. You must inform Wisconsin Medicaid in advance of any changes such as licensure, certification, group affiliation, corporate name, ownership, and physical or payee address. **Send your written notice to Wisconsin Medicaid Provider Maintenance** This notice must state when these changes take effect. Include your provider number(s) and signature. Do not write your notice or change on claims or prior authorization requests.

Failure to notify Wisconsin Medicaid of these types of changes may result in:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event provider mail is returned to Wisconsin Medicaid for lack of current address.

Provider Agreement Form

Your agreement to provide Medicaid services must be signed by you and the Wisconsin Department of Health and Family Services. This agreement states that both parties agree to abide by Wisconsin Medicaid's rules and regulations.

The agreement is valid for a maximum of one year. All Provider Agreements expire annually on March 31. The Department of Health and Family Services may renew or extend the Provider Agreement at that time.

You cannot transfer, assign, or change the Provider Agreement.

The application includes two copies of the Provider Agreement. Complete, sign, and return both copies. Type or clearly print your name as the applicant's name both on the line on page 1 and on the appropriate line on the last page of the agreement. You must use the same provider name on the application forms and Provider Agreement. When the certification process is complete, you will receive one copy of your processed and signed Provider Agreement. The other copy will be kept in your Wisconsin Medicaid file.

Terms of Reimbursement (TOR)

The TOR explains current reimbursement methodologies applicable to your particular provider type. It is referenced by, and incorporated within, the provider agreement. Keep the TOR for your files.

Certification Requirements

The Wisconsin Administrative Code contains requirements that providers must meet in order to be certified for Wisconsin Medicaid. The code and any special certification materials applicable to your provider type are included as certification requirements.

Publications

Along with your notice, Wisconsin Medicaid will send one copy of all applicable provider publications. The publications include program policies, procedures, and resources you can contact if you have questions.

Many clinics and groups have requested to receive only a few copies of each publication, rather than a personal copy for each Medicaid-certified individual provider in the clinic or group. If you are an individual provider who is a member of a Medicaid-certified clinic or group, you may reassign your copy to your clinic or group office. Please decide if you wish to receive your personal copy of Medicaid publications or if it is sufficient for your Medicaid-certified clinic or group office to receive copies.

If you do not wish to receive personal copies of Medicaid publications, please complete the attached "Deletion from Publications Mailing List Form." If you wish to have your copy of publications reassigned to your clinic or group, also complete the "Additional Publications Request Form."

HOME HEALTH AGENCY CERTIFICATION CRITERIA

Per section HFS 105.16, Wisconsin Administrative Code:

"For Medicaid certification, a home health agency shall be certified to participate in Medicare as a home health agency, be licensed pursuant to ch. HFS 133, and meet the requirements of this section as follows:

(1) HOME HEALTH AGENCY SERVICES. For Medicaid certification, a home health agency shall provide part-time, intermittent skilled nursing services performed by a registered nurse or licensed practical nurse and home health aide services and may provide physical therapy, occupational therapy, speech and language pathology services and medical supplies and equipment. Services may be provided only on visits to a recipient's home and that home may not be a hospital or nursing home. Home health services shall be provided in accordance with a written plan of care, which the physician shall review at least every 62 days or when the recipient' s medical condition changes, whichever occurs first.

(2) HOME HEALTH AIDES.

(a) Assignment and duties. Home health aides shall be assigned to specific recipients by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse, a physical or occupational therapist or a speech and language pathologist, as appropriate. Duties shall include medically oriented tasks, assistance with a recipient's activities of daily living and household tasks as specified in s. HFS 107.11(2)(b) and further described in the Wisconsin medical assistance home health agency provider handbook.

(b) Supervision. A registered nurse shall make supervisory visits to the recipient's home as often as necessary, but at least every 60 days, to review, monitor and evaluate the recipient's medical condition and medical needs according to the written plan of care during the period in which agency care is being provided. The RN shall evaluate the appropriateness of the relationship between the direct care giver and the recipient, assess the extent to which goals are being met, and determine if the current level of home health services provided to the recipient continues to be appropriate to treat the recipient's medical condition and if the services are medically necessary. The supervising RN shall discuss and review with the recipient the services received by the recipient and discuss the results of the supervisory visit with the LPN, home health aide or personal care worker. The results of each supervisory visit shall be documented in the recipient's medical record.

(c) Training. Home health aides shall be trained and tested in accordance with the requirements of s. 146.40, Stats., and ch. HFS 129. Aides shall not be assigned any tasks for which they are not trained, and training and competency in all assigned tasks shall be documented and made part of the provider's records.

(3) PHYSICAL THERAPISTS. Physical therapists may be employed by the home health agency or by an agency under contract to the home health agency, or may be independent providers under contract to the home health agency.

(4) OCCUPATIONAL THERAPISTS. Occupational therapists may be employed by the home health agency or by an agency under contract to the home health agency, or may be independent providers under contract to the home health agency.

(5) SPEECH AND LANGUAGE PATHOLOGISTS. Speech and language pathologists may be employed by the home health agency or by an agency under contract to the home health agency, or may be independent providers under contract to the home health agency."

(6) RESPIRATORY CARE SERVICES.

(a) A certified home health agency may be certified to provide respiratory care services under s. HFS 107.113 if registered nurses, licensed practical nurses and respiratory therapists employed by or under contract to the agency and providing these services are certified under ch. Med 20 and:

1. Are credentialed by the national board on respiratory care; or
2. Know how to perform services under s. HFS 107.113(1) and have the skills necessary to perform those services. Skills required to perform services listed in s. HFS 107.113(1)(e) to (f) are required on a case-by-case basis, as appropriate. In no case may a person provide respiratory care before that person has demonstrated competence in all areas under s. HFS 107.113(1)(a) to (d).

(b) A registered nurse who fulfills the requirements of this subsection shall coordinate the recipient's care

(c) The department shall review an agency's continued compliance with this subsection.

(7) PRIVATE DUTY NURSING. A home health agency may provide private duty nursing services under s. HFS 107.12 performed by a registered nurse or licensed practical nurse.

(8) COST REPORTS. The department may, when necessary, require home health agencies to report information which is supplementary to information required on Medicare cost reports.

(9) DEPARTMENT REVIEW.

(a) Record review. The department may periodically review the records described in this section and s. HFS 106.02(9), subject only to restrictions of law. All records shall be made immediately available upon the request of an authorized department representative.

(b) In-home visits. As part of the review under par. (a), the department may contact recipients who have received or are receiving Medicaid services from a home health care provider. The provider shall provided any identifying information requested by the department. The department may select the recipients for visits and may visit a recipient with the approval of the recipient or recipient's guardian. The recipient to be visited has the opportunity to have any person present whom he or she chooses, during the visit by personnel of the department or other governmental investigating agency.

(c) Investigation of complaints. The department may investigate any complaint received by it concerning the provision of Medicaid services by a home health care provider. Following the investigation, the department may issue a preliminary final report to the home health care provider in question, except when doing so would jeopardize any other investigation by the department or other state or federal agency.

(10) REQUIREMENTS FOR PROVIDING PRIVATE DUTY NURSING OR RESPIRATORY CARE SERVICES. For certified agencies providing private duty nursing or respiratory care services or both under this subsection, the following requirements apply:

Duties of the nurse.

1. The following nursing services may be performed only by a registered nurse:
   a. Making the initial evaluation visit;
   b. Initiating the physician's plan of care and necessary revisions;
   c. Providing those services that require care of a registered nurse as defined in ch. N 6.
   d. Initiating appropriate preventive and rehabilitative procedures.
   e. Accepting only those delegated medical acts which the RN is competent to perform based on his or her nursing education, training or experience; and

2. Nursing services not requiring a registered nurse may be provided by a licensed practical nurse under the supervision of a registered nurse. Licensed practical nurse duties include:
   a. Performing nursing care delegated by an RN under s. N 6.03;
   b. Assisting the patient in learning appropriate self-care techniques; and
   c. Meeting the nursing needs of the recipient according to the written plan of care.

3. Both RNs and LPNs shall:
   a. Arrange for or provide health care counseling within the scope of nursing practice to the recipient and recipient's family in meeting needs related to the recipient's condition.
   b. Provide coordination of care for the recipient;
   c. Accept only those delegated medical acts for which there are written or verbal orders and for which the nurse has appropriate training or experience;

d. Prepare written clinical notes that document the care provided within 24 hours of providing service and incorporate them into the recipient's clinical record within 7 days; and

e. Promptly inform the physician and other personnel participating in the patient's care of changes in the patient's condition and needs.

(b) Patient rights. A nurse shall provide a written statement of the rights of the recipient for whom services are provided to the recipient or guardian or any interested party prior to the provision of services. The recipient or guardian shall acknowledge receipt of the statement in writing. The nurse shall promote and protect the exercise of these rights and keep written documentation of compliance with this subsection. Each recipient receiving care shall have the following rights:

1. To be fully informed of all rules and regulations affecting the recipient;

2. To be fully informed of services to be provided by the nurse and of related charges, including any charges for services for which the recipient may be

3. To be fully informed of one's own health condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of services, including referral to a health care institution or other agency;

4. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of that refusal;

5. To confidential treatment of personal and medical records and to approve or refuse their release to any individual, except in the case of transfer to a health care facility;

6. To be taught, and have the family or other persons living with the recipient taught, the treatment required, so that the recipient can, to the extent possible, help himself or herself, and the family or other party designated by the recipient can understand and help the recipient;

7. To have one's property treated with respect; and

8. To complain about care that was provided or not provided, and to seek resolution of the complaint without fear of recrimination.

(c) Universal precautions. A nurse shall have the necessary orientation, education and training in epidemiology, modes of transmission and prevention of HIV and other blood-borne or body fluid-borne infections and shall follow universal blood and body-fluid precautions for each recipient for whom services are provided. The nurse shall employ protective measures recommended by the federal centers for disease control (CDC), including those pertaining to medical equipment and

supplies, to minimize the risk of infection from HIV and other blood-borne pathogens.

Note: A copy of the CDC recommended universal precautions may be obtained from the Bureau of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701-2969.

(d) Medical record. The nurse shall maintain a medical record for each recipient. The record shall document the nature and scope of all services provided and shall be systematically organized and readily accessible to authorized department personnel. The medical record shall document the recipient's condition, problems, progress and all services rendered, and shall include:

1. Recipient identification information;

2. Appropriate hospital information, including discharge information, diagnosis, current patient status and post-discharge plan of care;

3. Recipient admission evaluation and assessment;

4. All medical orders, including the physician's written plan of care and all interim physician's orders;

5. A consolidated list of medications, including start and stop dates, dosage, route of administration and frequency. This list shall be reviewed and updated for each nursing visit, if necessary;

6. Progress notes posted as frequently as necessary to clearly and accurately document the recipient's status and services provided. In this paragraph, "progress note" means a written notation, dated and signed by a member of the health team providing covered services, that summarizes facts about care furnished and the recipient's response during a given period of time;

7. Clinical notes written the day service is provided and incorporated into the clinical record within 7 days after the visit or recipient contact. In this paragraph, "clinical note" means a notation of a contact with a recipient that is written and dated by a member of the home health team providing covered services, and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition;

8. Written summaries of the recipient's care provided by the nurse to the physician at least every 62 days; and

9. Written authorizations from the recipient or the recipient's guardian when it is necessary for the nurse to procure medical supplies or equipment needed by the recipient, unless the recipient's care is being provided by an Medicaid-certified home health agency.

(e) Back-up and emergency procedures.

1. The recipient shall be informed of the identity of the agency-assigned alternate nurse before the alternate nurse provides services.

2. The nurse shall document a plan for recipient-specific emergency procedures in the event a life-threatening situation or fire occurs or there are severe weather warnings. This plan shall be made available to the recipient and all caregivers prior to initiation of these procedures.

3. The nurse shall take appropriate action and immediately notify the recipient's physician, guardian, if any, and any other responsible person designated in writing by the patient or guardian of any significant accident, injury or adverse change in the recipient's condition.

(f) Discharge of the recipient. A recipient shall be discharged from services provided by the nurse upon the recipient's request, upon the decision of the recipient's physician, or if the nurse documents that continuing to provide services to the recipient presents a direct threat to the nurse's health or safety and further documents the refusal of the attending physician to authorize discharge of the recipient with full knowledge and understanding of the threat to the nurse. The nurse shall recommend discharge to the physician and recipient if the recipient does not require services or requires services beyond the nurse's capability. The nurse provider shall issue a notification of discharge to the recipient or guardian, if possible, at least 2 calendar weeks prior to cessation of skilled nursing services and shall, in all circumstances, provide assistance in arranging for the continuity of all medically necessary care prior to discharge.

The Wisconsin Medicaid program must verify the Medicare certification before a provider number can be issued. **If available, send a copy of your Medicare certification notice with your application.**

Wisconsin licensure requirements state that all agencies providing home health services in the State of Wisconsin must be licensed in Wisconsin, without allowance for reciprocity with other states. If you are not licensed or Medicare certified, you must apply via a separate application. Information regarding licensure and Medicare certification may be obtained from the Bureau of Quality Assurance, P.O. Box 2969, Madison, WI 53701-2969.

Do not hold your application until you receive your Medicare certification. If you have not yet had your Medicare survey or received your Medicare certification notice, the Wisconsin Medicaid program will hold your application on file until a copy of your approval is received by the Wisconsin Medicaid program. You can facilitate this process by sending a copy of your Medicare certification notice to the Wisconsin Medicaid program as soon as you receive it. **You must send this notice to be received by Wisconsin Medicaid within 30 days of the letter's date for the earliest possible effective date to be assigned by the Wisconsin Medicaid program**.

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

HOME HEALTH SERVICES
TERMS OF REIMBURSEMENT

The Department will establish maximum allowable fees for all covered home health services provided to Wisconsin Medicaid Program recipients eligible on the date of service. The maximum allowable fees shall be based on various factors, including a review of usual and customary charges submitted to the Wisconsin Medicaid, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. The maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of Federal funding as specified in Federal law.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider of the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum allowable fees established by the Department. Wisconsin Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The Department will adjust payments made to providers to reflect the amounts of any allowable copayments which the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

Payments for deductibles and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with Federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

Applicable Provider Type(s): 33, 44, 45

Effective Date: July 1, 1992
Renewed: October 2000

PR08160.KZ/TOR

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Jim Doyle
Governor

Helene Nelson
Secretary

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

State of Wisconsin

Department of Health and Family Services

PRIVATE DUTY NURSING
TERMS OF REIMBURSEMENT

The Department will establish maximum allowable fees for all covered private duty nursing services provided to Wisconsin Medicaid recipients eligible on the date of service. The maximum allowable fees shall be based on various factors, including a review of usual and customary charges submitted to the Wisconsin Medicaid Program, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum allowable fee established by the Department. Wisconsin Medicaid Program reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The Department will adjust payments made to providers to reflect the amounts of any allowable copayments which the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

Applicable Provider Type(s): 33, 44, 45

Effective Date: January 1, 1992
Renewed/Revised*: September 1, 1997

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

RESPIRATORY CARE
TERMS OF REIMBURSEMENT

The Department will establish an hourly contracted rates for all covered respiratory care services provided to ventilator dependent Wisconsin Medicaid Program recipients eligible on the date of service, as mandated by 1989 Wisconsin Act 31. The hourly contracted rates shall be based on various factors, including a review of usual and customary charges submitted to the Wisconsin Medicaid, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. The hourly contracted rates may be adjusted to reflect reimbursement limits or limits on the availability of Federal funding as specified in Federal law.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider of the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered respiratory care service, the Department shall pay the hourly contracted rate established by the Department. Reimbursement for other home health services provided to ventilator dependent recipients will be in accordance with the applicable Home Health Agency or Private Duty Nurse Terms of Reimbursement. Wisconsin Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The Department will adjust payments made to providers to reflect the amounts of any allowable copayments which the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

Payments for deductibles and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with Federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting hourly contracted rates for services.

Applicable Provider Type(s): 41/All Specialties
33/Specialties 136, 137
44 (If certified for RCS)

Effective Date: April 1, 1991
Renewed: October 2000

WISCONSIN MEDICAID

PROVIDER APPLICATION INFORMATION AND INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary. However, in order to be certified, you must complete this form and submit it to the address indicated.

INSTRUCTIONS: Type or print your information on this application. Complete all sections. If a question does not apply to your application, write "N/A" in the field. Failure to complete all sections of this application will cause delay and may cause denial of certification.

IMPORTANT NOTICE: In receiving this application from and granting Medicaid certification to the individual or other entity named below as "Provider Applicant," Wisconsin Medicaid relies on the truth of all the following statements:

1. Provider Applicant submitted this application or authorized or otherwise caused it to be submitted.
2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted Provider Applicant will timely notify Wisconsin Medicaid of any such change.
3. By submitting this application or causing or authorizing it to be submitted, Provider Applicant agrees to abide by all statutes, rules, and policies governing Wisconsin Medicaid.
4. Provider Applicant knows and understands the certification requirements included in the application materials for the applicable provider types.

If any of the foregoing statements are not true, Wisconsin Medicaid may terminate Provider Applicant's certification or take other action authorized under ch. HFS106, Wis. Admin. Code, or other legal authority governing Wisconsin Medicaid.

DISTRIBUTION — Submit completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison WI 53784-0006

If you have any questions, call Provider Services at (800) 947-9627.

FOR OFFICE USE ONLY

ECN	Date Requested	Date Mailed

Provider Number	Effective Date
Provider Type	**Provider Specialty**

WISCONSIN MEDICAID
PROVIDER APPLICATION

INSTRUCTIONS: Type or print clearly. Before completing this application, read Information and Instructions.

This application is for:

☐ Individual.
☐ Group/Clinic.
☐ Change of Ownership, effective __ __/__ __ /__ __ __ __.

SECTION I — PROVIDER NAME AND PHYSICAL ADDRESS

Special Instructions
Name — Provider Applicant — Enter only one name. All applicants (e.g., individuals, groups, agencies, companies) must enter their name on this line. If your agency uses a "doing business as" (DBA), then enter your DBA name. The name entered on this line must exactly match the provider name used on all other documents for Wisconsin Medicaid.

Name — Group or Contact Person — Individual applicants employed by a group or agency should indicate their employer on this line. Applicants who are not employed by a group or agency may use this line as an additional name line or attention line to ensure proper mail delivery.

Address — Physical Work — Indicate address where services are primarily provided. Wisconsin Medicaid will send general information and correspondence to this address. Official correspondence will be sent certified. Failure to sign for official correspondence could result in decertification. It is not acceptable to use a drop box or post office box alone. Do not use a Medicaid recipient's residence or a billing service address.

Date of Birth — Individual / Social Security Number — Required for individual applicants only. Enter date as MM/DD/YYYY.

Name — Medicaid Contact Person, Telephone Numbers, and Fax Number — List the name, telephone number, and fax number of a person within your organization who can be contacted about Medicaid questions. Also list a telephone number clients can use to reach you. This telephone number must be kept current with Wisconsin Medicaid.

Medicare Part A Number and Medicare Part B Number — Required for Medicare-certified providers. Please use Medicare numbers appropriate for the same type of services as this application.

Name — Provider Applicant (Agency Name or Last, First Name, Middle Initial)			
Name — Group or Contact Person			
Address — Physical Work			
City	State	Zip Code	County
Date of Birth — Individual	SSN		Name — Medicaid Contact Person
Telephone Number — Medicaid Contact Person	Telephone Number — For Client Use		Fax Number
Current and/or Previous State Medicaid Provider Number ☐ Wisconsin ☐ Other			
Medicare Part A Number			Effective Date
Medicare Part B Number			Effective Date

SECTION II — ADDITIONAL INFORMATION

Special Instructions
Respond to all applicable items:

- **All applicants must complete question 1. Providers with a physical address in Minnesota, Michigan, Iowa, or Illinois** must attach a copy of their current license.
- **Physicians** must answer **question 2**.
- **Applicants who will bill for laboratory tests** must answer **question 3**. Attach a copy of their current Clinical Laboratory Improvement Amendment (CLIA) certificate.
- **All applicants certified to prescribe drugs** must answer **question 4**.
- **Individuals affiliated with a Medicaid-certified group** must answer **question 5**.

1. Individual or Agency License, Certification, or Regulation Number(s)

2. Unique Physician Identification Number (UPIN)

3. CLIA Number

4. Drug Enforcement Administration (DEA) Number

5. Medicaid Clinic/Group Number

SECTION III — PROVIDER PAYEE NAME AND PAYEE ADDRESS

Special Instructions
Name — Payee — Enter the name to whom checks are payable. Individuals reporting income to the Internal Revenue Service (IRS) under a SSN must enter the individual name recorded with the IRS for the SSN. Applicants reporting income to the IRS under an employer identification number (EIN) must enter the name exactly as it is recorded with the IRS for the EIN.

TIN — Enter the Taxpayer Identification Number (TIN) that should be used to report income to the IRS. Check whether the TIN is an EIN or SSN. The number entered must be the TIN of the payee name entered. The payee name and TIN must exactly match what is on record with the IRS.

TIN Effective Date — This is the date the TIN became effective for the provider.

Name — Group or Contact Person (Optional) — Enter an additional name (e.g., business, group, agency) that should be printed on checks and Remittance and Status (R/S) Reports (payment/denial report) to ensure proper delivery.

Address — Payee — Indicate where checks and R/S Reports should be mailed. A post office box alone may be used for this address.

Name — Payee

TIN	TIN Effective Date	☐ EIN or ☐ SSN

Name — Group or Contact Person

Address — Payee

City	County	State	Zip Code

SECTION IV — TYPE OF CERTIFICATION

Check the provider type for this application from the list below. A separate application is required (in most cases) for each provider type for which you wish to be certified. An individual may choose only one provider type per application.

- ☐ Ambulance.
- ☐ Ambulatory Surgery Center.
- ☐ Anesthesiology Assistant*.
- ☐ Anesthetist CRNA.
- ☐ Audiologist.
- ☐ Audiologist/Hearing Instrument Specialist.
- ☐ Case Management.
- ☐ Chiropractor.
- ☐ Community Care Organization.
- ☐ Dentist, Specialty _____.
- ☐ End Stage Renal Disease.
- ☐ Family Planning Clinic.
- ☐ HealthCheck Screener.
- ☐ HealthCheck "Other" Services:
  - ☐ Other Eligible Services.
- ☐ Hearing Instrument Specialist.
- ☐ Home Health Agency:
  - ☐ With Personal Care.
  - ☐ With Respiratory Care.
- ☐ Hospice.
- ☐ Independent Lab.
- ☐ Individual Medical Supply:
  - ☐ Orthodontist and/or: Prosthetist.
    Other _____.
- ☐ Medical Vendor/Durable Medical Equipment (DME).
- ☐ Nurse Practitioner:
  - ☐ Certified Nurse Midwife (masters level or equivalent).
- ☐ Nurse Services (Independent Home Care):
  - ☐ Respiratory Care Services.
  - ☐ Private Duty.
  - ☐ Midwife.
- ☐ Occupational Therapy (OT).
- ☐ OT Assistant*.
- ☐ Optician.
- ☐ Optometrist.
- ☐ Osteopath (See below).
- ☐ Osteopath Group/Clinic (See below).
- ☐ Personal Care Agency.
- ☐ Pharmacy.
- ☐ Physical Therapy (PT).
- ☐ PT Assistant*.
- ☐ Physician (See below).
- ☐ Physician Assistant*.
- ☐ Physician Group/Clinic (See below).
- ☐ Podiatrist.
- ☐ Portable X-ray.
- ☐ Prenatal Care Coordination (PNCC).
- ☐ Rehabilitation Agency.
- ☐ Respiratory Therapist.
- ☐ Rural Health Clinic.
- ☐ School-Based Services.
- ☐ Specialized Medical Vehicle Transportation.
- ☐ Speech and Hearing Clinic.
- ☐ Speech and Pathology:
  - ☐ Master's Level.
  - ☐ Bachelor's Level*.
- ☐ Therapy Group (Two therapies, i.e., OT and PT).
- ☐ Others (Describe): _____
  _____.

*Individuals must be supervised and cannot independently bill Wisconsin Medicaid. In most cases, the clinic must submit claims.

Osteopaths or physicians, or a group/clinic of an osteopath or physician, must indicate the specialty below (select one specialty):

- ☐ Allergy.
- ☐ Anesthesiology.
- ☐ Cardiovascular Disease.
- ☐ Clinic.
- ☐ Dermatology.
- ☐ Ear, Nose, Throat Otorhinolaryngology.
- ☐ Emergency Medicine.
- ☐ Family Practice.
- ☐ Gastroenterology.
- ☐ General Practice.
- ☐ General Surgery.
- ☐ Geriatrics.
- ☐ Internal Medicine.
- ☐ Manipulative Therapy.
- ☐ Miscellaneous.
- ☐ Nephrology.
- ☐ Neurological Surgery.
- ☐ Neurology.
- ☐ Nuclear Medicine.
- ☐ Obstetrics and Gynecology.
- ☐ Oncology and Hematology.
- ☐ Ophthalmology.
- ☐ Optometry.
- ☐ Orthopedic Surgery.
- ☐ Pathology.
- ☐ Pediatrics.
- ☐ Pediatric Allergy.
- ☐ Pediatric Cardiology.
- ☐ Physical Medicine and Rehab.
- ☐ Plastic Surgery.
- ☐ Preventive Medicine.
- ☐ Proctology.
- ☐ Psychiatry (MDs attach a proof of completed psychiatric residency).
- ☐ Pulmonary Disease.
- ☐ Radiation Therapy.
- ☐ Radiology.
- ☐ Thoracic and Cardiovascular Surgery.
- ☐ Urgent Care.
- ☐ Urology.

SECTION V — MEMBERS OF GROUP OR CLINIC

Required: If this application is for a group or clinic, complete the chart below by listing all individuals providing Medicaid services at the clinic.

Name — Provider	Address — Provider Physical Work	Specialty	License Number	Provider Number

SECTION VI — APPLICANT'S TYPES OF SERVICE PROVIDED AND TYPE OF BUSINESS

1. List the types of Medicaid services the applicant's agency will provide (such as dental, emergency transportation, home health, personal care, pharmacy, physician, psychiatric counseling, respiratory care services, etc.).

2. Applicant's type of business (check appropriate box):

- ☐ Individual.
- ☐ Sole Proprietor:
  County and state where registered _____.
- ☐ Corporation for Nonprofit.
- ☐ Limited Liability.
- ☐ Corporation for Profit.
  State of registration _____

  Names of corporate officers _____

  _____
- ☐ Partnership.
  State of registration _____.

  Names of all partners and SSNs (use additional sheet if needed):

  Name _____ SSN _____

  Name _____ SSN _____

Governmental (check one):

- ☐ County.
- ☐ State.
- ☐ Municipality (city, town, village).
- ☐ Tribal.

- ☐ Other, specify _____.

Definitions for Sections VII-IX

Controlling interest — Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage holders, employees or stockholders with holdings of 10% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

SECTION VII — TERMINATION / CONVICTION / SANCTION INFORMATION

Has the applicant, any employee of the applicant, any person in whom the applicant has a controlling interest, or any person having a controlling interest in the applicant been terminated from or convicted of a crime related to a federal or state program?

☐ **Yes** ☐ **No**

If yes, please explain:

SECTION VIII — CONTROLLING INTEREST IN OTHER HEALTH CARE PROVIDERS

Copy this page and complete as needed.

Does the applicant have a controlling interest in any vendors of special service categories such as, but not limited to, drugs/pharmacy, medical supplies/durable medical equipment, transportation, visiting nurse and/or home health agency, providers of any type of therapy?

☐ **Yes.** Identify each health care provider the applicant has a controlling interest or ownership in, supply the information, and describe the type and percentage of controlling interest or ownership (e.g., 5% owner, 50% partner, administrator).
☐ **No.** Go to Section IX.

Name			
Medical Provider Number(s)	SSN/EIN		
Address			
City	State	Zip Code	County
Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership	

Are all of the services provided by the applicant and any special service vendors in which the applicant has a controlling interest billed under a single provider number?

☐ **Yes.** Enter the number:_____.
☐ **No.**

SECTION IX — CONTROLLING INTEREST OTHERS (INDIVIDUAL AND / OR ENTITY) HAVE IN THE APPLICANT

Copy this page and complete as needed.

Does any person and/or entity have a controlling interest in any of the Medicaid services the applicant provides? ☐ **Yes** ☐ **No**

If yes, list the names and addresses of all persons and/or entities with a controlling interest in the applicant.

Name — Individual or Entity			
Address			
City	State	Zip Code	County
Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership	
SSN or IRS Tax Number	Provider Number, if applicable		

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Jim Doyle
Governor

Helene Nelson
Secretary

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

State of Wisconsin

Department of Health and Family Services

WISCONSIN MEDICAID PROGRAM
RESPIRATORY CARE SERVICES AFFIDAVIT

I hereby affirm that _____ is or employs one or more
(Name of respiratory care services provider)
of the following (check as many as apply):

☐ Registered Nurse(s) (RN) registered pursuant to s. 441.06, Stats.

☐ Licensed Practical Nurse(s) (LPN) licensed pursuant to s. 441.10, Stats.

☐ Respiratory Therapist(s) (RT).

Credentialed by the National Board of Respiratory Care or qualified to perform the following respiratory care services necessary for providing adequate care for a home ventilator-assisted recipient under the Wisconsin Medicaid Program:

1. Airway management, including:
   - A. Tracheostomy care (types of tracheostomy tubes, stoma care, changing a tracheostomy tube, and emergency procedures for tracheostomy care);
   - B. Tracheal suctioning technique; and
   - C. Airway humidification.

2. Oxygen therapy (operation of oxygen systems and auxiliary oxygen delivery devices).

3. Respiratory assessment (knowledge of and skills in respiratory assessment to include, but not limited to, monitoring of breath sounds, patient color, chest excursion, secretions, and vital signs).

4. Ventilator Management:
   - A. Operation of positive pressure ventilator by means of tracheostomy to include, but not limited to, different modes of ventilation, types of alarms and responding to alarms, troubleshooting ventilator dysfunction, operation and assembly of ventilator circuit (delivery system) and proper cleaning and disinfection of equipment;
   - B. Operation of a manual resuscitator; and Emergency assessment and management, including cardiopulmonary resuscitation (CRP).

5. Other modes of ventilatory support:
   - A. Positive pressure ventilation via nasal mask or mouthpiece;
   - B. Continuous positive airway pressure (CPAP) via tracheostomy tube or mask;
   - C. Negative pressure ventilation (iron lung, chest shell or pulmowrap;

D. Rocking beds;
E. Pneumobelts; and
F. Diaphragm pacing.

6. Operation and interpretation of monitoring devices:
   A. Cardio-respiratory monitoring;
   B. Pulse oximetry; and
   C. Capnography.

7. Knowledge of and skills in weaning from the ventilator:

8. Adjunctive techniques:
   A. Chest physiotherapy; and
   B. Aerosolized medications.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services.

I further affirm that all ventilator-assisted recipients cared for at home are:

1. Medically dependent on a ventilator for life support at least six (6) hours per day; and
2. Has been so dependent for at least 30 consecutive days at any point in time as an inpatient in one or more hospitals, skilled nursing facilities (SNFs), or intermediate care facilities (ICFs).

I affirm that all of the above are true representations to the best of my knowledge.

Signed:

_____
Signature

_____ _____
Printed Name/Title Date

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DOH 1111A (Rev. 9.97)
DHFS/HEALTH
Wis. Adm. Code HSS 105.01

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT

(Standard: for individual and most clinic/group/agency providers)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with **(fill in name here)**

Provider Name: _____,
(Provider's Name and Number (if assigned). Name must exactly match the name used on all other documents)
a provider of health care services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid Program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid Program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and all other publications, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended.

2. The Department shall reimburse the Provider for services and items properly provided under the program in accordance with the "Terms of Reimbursement," as are now in effect or as may later be amended.

3. In accordance with 42 CFR s. 431.107 of the federal Medicaid regulations, the Provider agrees to keep any records necessary to disclose the extent of services provided to recipients, upon request, and to furnish to the Department, the Secretary of the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program.

4. The Provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. The Provider shall furnish to the Department in writing:

(a) the names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

(b) the names and addresses of all persons who have a controlling interest in the Provider;

(c) whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;

(d) the names, addresses, and any significant business transactions between the Provider and any subcontractor;

(e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title 20 services programs since the inception of those programs.

5. The Provider hereby affirms that it and each person employed by it for the purpose of providing services holds all licenses or similar entitlements as specified in HFS 101 to 108, Wisconsin Administrative Code, and required by federal or state statute, regulation, or rule for the provision of the service.

6. The Provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the Provider to the Wisconsin Medicaid Program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

7. Unless earlier terminated as provided in paragraph 8 below, this agreement shall remain in full force and effect for a maximum of one year, with the agreement expiring annually on March 31. Renewal shall be governed by s. HFS 105.02(8), Wisconsin Administrative Code.

8. This agreement may be terminated as follows:

   (a) By the Provider as provided at s. HFS 106.05, Wisconsin Administrative Code.

   (b) By the Department upon grounds set forth at s. HFS 106.06, Wisconsin Administrative Code.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services."

SIGNATURES FOLLOW ON PAGE 3

ALL THREE PAGES OF THIS PROVIDER AGREEMENT MUST BE RETURNED TOGETHER.

_____ Name of Provider (Typed or Printed)	(For Department Use Only) STATE OF WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES
_____ Physical Street Address	
_____ City State Zip	
TITLE: _____	
BY: _____ Signature of Provider	**BY:** _____
DATE: _____	**DATE:** _____

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

PRINT CLEARLY, THIS IS YOUR MAILING LABEL. For recertification (renewals) ONLY. Fill in the address below **IF** the processed Provider Agreement should be sent to a different address than the physical street address above.

_____
_____
_____
_____

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DOH 1111A (Rev. 9.97)
DHFS/HEALTH
Wis. Adm. Code HSS 105.01

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT

(Standard: for individual and most clinic/group/agency providers)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with **(fill in name here)**

Provider Name: _____,
(Provider's Name and Number (if assigned). Name must exactly match the name used on all other documents)
a provider of health care services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid Program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid Program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and all other publications, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended.

2. The Department shall reimburse the Provider for services and items properly provided under the program in accordance with the "Terms of Reimbursement," as are now in effect or as may later be amended.

3. In accordance with 42 CFR s. 431.107 of the federal Medicaid regulations, the Provider agrees to keep any records necessary to disclose the extent of services provided to recipients, upon request, and to furnish to the Department, the Secretary of the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program.

4. The Provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. The Provider shall furnish to the Department in writing:

(a) the names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

(b) the names and addresses of all persons who have a controlling interest in the Provider;

(c) whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;

(d) the names, addresses, and any significant business transactions between the Provider and any subcontractor;

(e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title 20 services programs since the inception of those programs.

5. The Provider hereby affirms that it and each person employed by it for the purpose of providing services holds all licenses or similar entitlements as specified in HFS 101 to 108, Wisconsin Administrative Code, and required by federal or state statute, regulation, or rule for the provision of the service.

6. The Provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the Provider to the Wisconsin Medicaid Program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

7. Unless earlier terminated as provided in paragraph 8 below, this agreement shall remain in full force and effect for a maximum of one year, with the agreement expiring annually on March 31. Renewal shall be governed by s. HFS 105.02(8), Wisconsin Administrative Code.

8. This agreement may be terminated as follows:

   (a) By the Provider as provided at s. HFS 106.05, Wisconsin Administrative Code.

   (b) By the Department upon grounds set forth at s. HFS 106.06, Wisconsin Administrative Code.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services."

SIGNATURES FOLLOW ON PAGE 3

ALL THREE PAGES OF THIS PROVIDER AGREEMENT MUST BE RETURNED TOGETHER.

_____ Name of Provider (Typed or Printed)	(For Department Use Only) STATE OF WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES
_____ Physical Street Address	
_____ City State Zip	
TITLE: _____	
BY: _____ Signature of Provider	**BY:** _____
DATE: _____	**DATE:** _____

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

PRINT CLEARLY, THIS IS YOUR MAILING LABEL. For recertification (renewals) ONLY. Fill in the address below **IF** the processed Provider Agreement should be sent to a different address than the physical street address above.

_____
_____
_____
_____

WISCONSIN MEDICAID
ELECTRONIC BILLING GENERAL INFORMATION

Wisconsin Medicaid has several electronic billing options available for trading partners to submit electronic claims. HIPAA compliant Software is available at no cost for submitting claims to Wisconsin Medicaid except for retail pharmacy services. For further information, or to order free software refer to: *dhfs.wisconsin.gov/medicaid9/pes/pes.htm* or contact the Provider Services at 1-800-947-9627 or the EDI Department at 608-221-9036.

ELECTRONIC METHODS FOR SUBMITTING MEDICAID CLAIMS

- Provider Electronic Solutions (PES) – Wisconsin Medicaid HIPAA Compliant Free Software
    - 837 Institutional
    - 837 Professional
    - 837 Dental
    - 997 Functional Acknowledgement
    - 835 Health Care Payment Advice

- Cartridge - Providers with the capability to create their claim information on 3480, 3490 or 3490E cartridge can submit those tapes to Wisconsin Medicaid in the HIPAA compliant formats.

- RAS/Internet – Allows providers to send their data files to Wisconsin Medicaid using a direct RAS connection or Web Browser.

- Third Party Biller – Providers have the option of purchasing a billing system or contracting with a Third Party Biller, to submit their claims.